INITIAL STATEMENT OF REASONS
FOR THE PROPOSED CHANGES TO THE
OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT'S
ACCOUNTING AND REPORTING MANUAL FOR CALIFORNIA HOSPITALS - Second Edition

The Office of Statewide Health Planning and Development (OSHPD or the "Office") proposes changes to the Second Edition of the *Accounting and Reporting Manual for California Hospitals*, as amended December 5, 1996, (the "Manual"), Section 97018 of Title 22 of the California Code of Regulations which incorporates the Manual by reference, and Section 97041 which describes the reporting procedures for the Hospital Annual Disclosure Report and Hospital Quarterly Financial and Utilization Report.

ADMINISTRATIVE REQUIREMENTS, SPECIFIC PURPOSES, AND RATIONALE

The Health Data and Advisory Council Consolidation Act of 1984 (California Health and Safety Code Sections 128675 through 128815) requires OSHPD to maintain a uniform system of accounting for non-federal California hospitals and that all such hospitals use that system in their books and records on a day-to-day basis. As part of its responsibility to maintain a uniform hospital system of accounting, OSHPD is obligated to update that system to meet the current accounting needs of hospitals using that system. The uniform system provides the foundation for the collection and reporting of specific data on an annual and quarterly basis to OSHPD. The underlying objective of the reporting requirement is to provide the public, the hospital industry, and State policy makers accurate, uniform, and objective information regarding the revenues, expenses, assets, liabilities, equity, capacity, and utilization of California hospitals. As public information, these data are and will continue to be available to officials at all levels of state and local government for their use in formulating and evaluating health system policies and in managing governmental health delivery programs. These data are also available to health care consultants, employers, insurers, organized labor, and other health care purchasers who may use the information to make informed decisions in today's health care market. Finally, the data are available to health service providers who may use the information for health facility management and strategic planning purposes.

The following revisions to the Second Edition of the Manual are proposed:

- update the payer categories by including payer categories for Medicare - Managed Care, Medi-Cal - Managed Care, County Indigent Programs - Managed Care, and Other Third Parties - Managed Care to accommodate hospitals' need for recording revenue, expenses, and statistics related to providing services to managed care patients;

- rename the current payer categories for Medicare, Medi-Cal, County Indigent Programs, and Other Third Parties to Medicare - Traditional, Medi-Cal - Traditional, County Indigent Programs - Traditional, and Other Third Parties - Traditional to better identify and distinguish these categories from managed care;

- add a payer category, Other Indigent, for indigent patients, excluding those recorded in the County Indigent Programs category and including those being provided charity care by the hospital, to separately identify services related to these patients;

- separate capitation premium revenue accounts from the deductions from revenue accounts to be consistent with Generally Accepted Accounting Principles (GAAP);

- eliminate the revenue account for purchased inpatient services since recording the revenue provides no meaningful information and distorts the calculations resulting from the cost allocation process;

- add an expense account for purchased outpatient services to separately identify these managed care services from managed care services provided within the hospital;

- eliminate managed care patient utilization statistics from Annual Disclosure Report page 3.3, item H, because managed care patient utilization data is being added in proposed new report page 4.1, Patient Utilization Statistics by Payor;

- revise Annual Disclosure Report page 4.1, Patient Census Statistics, and report page 4.2, Ambulatory, Ancillary, and Other Utilization Statistics, to eliminate the reporting of payer detail by cost center;

- combine Annual Disclosure Report pages 4.1 and 4.2 as report page 4 and title it as Patient Utilization Statistics to simplify reporting requirements;

- create new Annual Disclosure Report page 4.1, Patient Utilization Statistics by Payor, to accommodate the reporting of payer category detail for patient days and discharges by type of care, and payer category detail for outpatient visits by type of outpatient visit;

- change the display of operating expenses on Annual Disclosure Report page 8 from natural classification of expense to functional service to be consistent with GAAP;

- eliminate Annual Disclosure Report page 8.1 and combine the non-operating revenue and expense items on report page 8, Statement of Income, to simplify reporting requirements;

- require each hospital to have the capability to use future versions of the Hospital Quarterly Reporting System (HQRS) software running under Windows 95 or later, or Windows NT operating systems; and

- make other minor or clarifying changes.

Section 97018, Accounting and Reporting Manual for California Hospitals, of Title 22 of the California Coded of Regulations is being amended to reflect the effective date of the above changes.

Section 97041, Report Procedure, of Title 22, California Code of Regulations is also being amended to update references to the Hospital Quarterly Reporting System, the Instructions and Specifications for Developing Approved Software to Submit the California Hospital Annual Disclosure Report on Personal Computer Diskette, and the Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 ¼" or 3 ½" IBM PC Compatible Diskette.

The proposed accounting and reporting changes would be effective 30 days after filing with the Secretary of State. The first Hospital Annual Disclosure Reports to reflect the new reporting requirements would be for hospital fiscal years beginning on or after July 1, 1999. The first Quarterly Financial and Utilization Reports affected by the HQRS software change in personal computer operating system requirements from DOS to Windows 95 will be January 1, 1999. All other proposed changes that affect the quarterly report will be for calendar quarters beginning January 1, 2000.

SIGNIFICANT CHANGES to the HOSPITAL ACCOUNTING AND REPORTING MANUAL:

Expanded Payer Categories

When the Office issued the Second Edition of the *Accounting and Reporting Manual for California Hospitals* (Manual) in April 1991, the accounting and reporting system requirements specified that hospitals must separately record and report financial and utilization data by five payer categories, Medicare, Medi-Cal, County Indigent Programs, Other Third Parties, and Other Payors. At that time, terms such as "risk-based capitation" and "managed care" were relatively unknown. There was little need to track financial and utilization data associated with managed care patients separately.

Since that time, managed care delivery systems have expanded dramatically. Managed care patients now constitute a significant percentage of California's patient population, especially since Medicare and Medi-Cal beneficiaries can, or are required to, enroll in such plans. In a managed care survey conducted by the Office, 83 percent of hospitals responding expressed the need to record gross patient revenue, related deductions from revenue, and utilization data related to managed care plans separately from those data for other patients.

The current accounting and reporting system requirements do not provide the necessary guidance or information from which meaningful decisions can be made related to managed care. For example, patients enrolled in managed care plans funded by Medicare and Medi-Cal are currently reported under the Other Third Parties payer category, which understates the true level of Medicare and Medi-Cal patient activity.

To address this issue, four managed care payer categories related to Medicare, Medi-Cal, County Indigent Programs, and Other Third Parties are being added to the Manual to separately account and report patient days, hospital discharges, outpatient visits, patient revenue, deductions from revenue, and capitation premium revenue for patients covered by managed care plans. Managed care patients are persons enrolled in a managed care plan to receive health care from hospitals on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option (POS), etc.).

Also, a payer category, Other Indigent, is being added to the Manual to separately identify patient days, discharges, outpatient visits, and patient revenue for indigent patients, excluding those recorded in the County Indigent Programs category and including those being provided charity care by the hospital. Under the current Manual, all data related to these indigent patients are included in the Other Payors category. This change is necessary to identify financial and utilization data related to all indigent patients.

After updating the payer categories in the Manual, the payer categories would be:

1) Medicare - Traditional includes patients covered by the Social Security Amendments of 1965 other than those covered by a managed care plan funded by Medicare. These patients are primarily the aged and needy.

2) Medicare - Managed Care includes patients who are covered by a managed care plan funded by Medicare. Medicare patients are covered by the Social Security Amendments of 1965 and are primarily the aged and needy.

3) Medi-Cal - Traditional includes patients who are qualified as needy under state laws other than those covered by a managed care plan funded by Medi-Cal.

4) Medi-Cal - Managed Care includes patients who are covered by a managed care plan funded by Medi-Cal. Medi-cal patients are those patients who are qualified as needy under state laws.

5) County Indigent Programs - Traditional includes indigent patients covered under Welfare and Institution Code Section 17000 other than those covered by a managed care plan funded by a county. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources for which the hospital renders a bill or other claim for payment to a county. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered.

6) County Indigent Programs - Managed Care includes indigent patients covered under Welfare and Institution Code Section 17000 and are covered by a managed care health plan funded by a county.

7) Other Third Parties - Traditional includes all other forms of health coverage excluding managed care plans. Examples include indemnity plans, fee-for-service plans, Short-Doyle, Tricare (CHAMPUS), IRCA/SLIAG, California Children's Services, and Workers' Compensation.

8) Other Third Parties - Managed Care includes patients covered by managed care plans other than those funded by Medicare, Medi-Cal, or a county.

9) Other Indigent includes indigent patients, excluding those recorded in the County Indigent Programs category and including those being provided charity care by the hospital.

10) Other Payors includes all patients who are not included in the categories listed above, such as those

designated as self-pay and U.C. teaching hospital patients who are provided care with Support for Clinical Teaching funds.

Because of the expansion in payer categories, accounts in the following areas were either added, renamed, or renumbered: patient receivables, allowance for contractual adjustments, patient revenue, deductions from revenue, and capitation premium revenue.

Patient Receivable Accounts and Allowance for Contractual Adjustments Accounts

Currently, patient receivable accounts and allowance for contractual adjustments accounts are separated between inpatient and outpatient by payer category using subaccounts. Due to limited available account numbers, inpatient and outpatient accounts are being combined to allow for expanded payer category detail in the subaccounts.

Patient Revenue Accounts

The numeric coding system in the Chart of Accounts uses six digits. Account numbers include four digits to the left of the decimal point, which identify primary account classifications, and two digits to the right, which identify secondary account classifications (subclassifications). The subclassifications for patient revenue accounts are being revised to accommodate the revised payer categories.

The following tables show the current subclassifications of revenue and proposed subclassifications of revenue.

Current Subclassifications of Revenue

DECIMAL POINT	Digit	Patient Classification Description	Digit	Financial Status Classification Description
.	0	Inpatient	0	Self-Pay
.	1	Optional	1	HMO/PPO Contracts
.	2	Optional	2	Commercial Insurance
.	3	Optional	3	Workers' Compensation
.	4	Outpatient	4	Medicare
.	5	Optional	5	Medi-Cal
.	6	Optional	6	Short-Doyle
.	7	Optional	7	County Indigent Programs
.	8	Optional	8	Charity
.	9	Optional	9	Other

Proposed Subclassifications of Revenue

DECIMAL POINT	Digit	Patient Classification Description	Digit	Financial Status Classification Description
.	0	Inpatient - Traditional	0	Self-Pay
.	1	Inpatient - Managed Care	1	Not Assigned
.	2	Not Assigned	2	Private Coverage
.	3	Not Assigned	3	Workers' Compensation
.	4	Outpatient - Traditional	4	Medicare
.	5	Outpatient - Managed Care	5	Medi-Cal
.	6	Not Assigned	6	Other Government
.	7	Not Assigned	7	County Indigent Programs
.	8	Not Assigned	8	Other Indigent
.	9	Not Assigned	9	Other

Deductions from Revenue Accounts and Capitation Premium Revenue Accounts

To accommodate the revised payer categories, deduction from revenue accounts were either added, renamed, or renumbered. Capitation premium revenue accounts are also added and renumbered.

To implement the payer category changes, the following Manual sections are being added:

2210.6 Capitation Premium Revenue Accounts;
2410.6 Description of Capitation Premium Revenue Accounts;

and the following Manual sections are being amended:

1110 Timing Differences;
1200 Accounting for Medicare Reimbursement;
1201 Outlier Payments;
1202 Cost Based Reimbursement;
1220 Accounting for Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts;
1221.1 Example of Capitation Accounting Entries;
1222 Outpatient Services;
1260 Accounting for County Indigent Programs and Funds;
1270 Accounting for Medi-Cal Disproportionate Share Payments;
1280 Accounting for Realignment Funds (County Hospitals Only);
2110.1 Current Asset Accounts;
2210.5 Deductions From Revenue Accounts;
2230 Subclassifications of Patient Revenue Accounts and Deductions From Revenue;
2310.1 Description of Current Asset Accounts;
2410.5 Description of Deductions From Revenue Accounts;
2430 Description of Subclassification of Patient Services Revenue Accounts and Deductions From Revenue;
6101 Tobacco Tax Funds Received by Non-County Hospitals;
6103 SB 1255 Medi-Cal Disproportionate Share Program;
7010 List of Reporting Forms;
7020.1 Reclassifications;
7020.2 Instructions for Completing Supplemental Patient Revenue Information, Report Page 12;
7020.12 Instructions for Completing Statement of Income - Unrestricted Fund, Report Page 8;
7020.15 Instructions for Completing Related Hospital Information, Report Page 3.3;
7020.16 Instructions for Completing Patient Census Statistics, Report Page 4.1;
7020.17 Instructions for completing Ambulatory, Ancillary, and Other Utilization Statistics, Report Page 4.2;
7030 Annual Reporting Forms (pages 3.3, 4.1, 4.2, 8, and 12);
8100 General Instructions for Completing the Quarterly Report;
8200 Detailed Instructions for Completing the Quarterly Report; and
8300 Quarterly Reporting Form.

Separate Capitation Premium Revenue from Deductions from Revenue

Capitation premium revenue related to the new managed care payer categories are being separated from and displayed after deductions from revenue on the Hospital Annual Disclosure Report and Hospital Quarterly Financial and Utilization Report. This change is necessary to be consistent with Generally Accepted Accounting Principles which do not include capitation premium revenue in deductions from revenue. Although capitation premium revenue is being separated from deductions from revenue, capitation premium revenue will still be included in the net patient revenue.

To separate capitation premium revenue from deductions from revenue, the following Manual sections are being added:

2210.6 Capitation Premium Revenue Accounts;
2410.6 Description of Capitation Premium Revenue Accounts;

and the following Manual sections are being amended:

1220 Accounting for Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts;
1221 Accounting for Inpatient Services Related to Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts;
1221.1 Example of Capitation Accounting Entries;
2210.5 Deductions From Revenue Accounts;
2410.5 Description of Deductions From Revenue Accounts;
7020.2 Instructions for Completing Supplemental Patient Revenue Information, Report Page 12;
7020.12 Instructions for Completing Statement of Income - Unrestricted Fund, Report Page 8;
7030 Annual Reporting Forms (pages 8, and 12);
8200 Detailed Instructions for Completing the Quarterly Report; and
8300 Quarterly Reporting Form.

Eliminate Revenue Account for Purchased Inpatient Services

The System of Accounts (Chapter 2000 of the Manual) is being changed to eliminate the revenue account for Purchased Inpatient Services (Account 4900). Recording the Purchased Inpatient Services revenue for managed care patients provides no meaningful information and distorts the calculations resulting from the cost allocation process. It is unnecessary for hospitals to record purchased inpatient services revenue for managed care patients since revenue for these services is included in the capitation premium revenue account.

To implement the above changes the following Manual sections are being amended:

1221 Accounting for Inpatient Services Related to Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts;
1221.1 Example of Capitation Accounting Entries;
1250 Accounting for Medical Services Purchased From Another Facility;
2210.3 Ancillary Service Revenue;
2410.3 Description of Ancillary Service Revenue;
7020.2 Instructions for Completing Supplemental Patient Revenue Information, Report Page 12;
7020.08 Instructiuons for Completing Cost Allocation - Statistical Basis Short Form, Report Page 19a;
7020.9 Instructions for Completing Cost Allocation Short Form, Report Page 20a;
7020.10 Instructions for Completing Cost Allocation - Statistical Basis and Cost Allocation, Report Pages 19 and 20;
7020.12 Instructions for Completing Statement of Income - Unrestricted Fund, Report Page 8;
7030 Annual Reporting Forms (pages 8 and 17);
8200 Detailed Instructions for Completing the Quarterly Report; and
8300 Quarterly Reporting Form.

Add Expense Account for Purchased Outpatient Services

The System of Accounts (Chapter 2000 of the Manual) is being changed to add a cost center account for Purchased Outpatient Services (Account 7950) related to managed care patients. Under the current accounting and reporting system requirements, outpatient services purchased from another facility must be accounted and reported by functional cost center, i.e., Emergency Services, Clinical Laboratory Services,

Magnetic Resonance Imaging, etc. This requires the hospitals purchasing outpatient services to obtain functional cost center detail from the facilities they are purchasing outpatient services from. Some hospitals have requested establishing a purchased outpatient services cost center to reduce the burden of tracking revenue, expenses, and standard units of measure by functional revenue/cost center for outpatient services purchased from other facilities.

When a hospital must purchase outpatient services from other facilities for managed care patients who are not registered as outpatients of the purchasing hospital, the related expenses must be accounted and reported in the new Purchased Outpatient Services (Account 7950) cost center by the purchasing hospital. This reduces the burden of functionally recording and reporting outpatient services purchased from other facilities. No revenue account is being added for the purchased outpatient services since hospitals will be recording capitation premium revenue for these services. No meaningful standard unit of measure can be determined, so no standard unit of measure is being added for this cost center.

On the Hospital Quarterly Financial and Utilization Report, purchased outpatient services expenses is being added as an optional item.

To implement the above changes the following Manual sections are being amended:

1222	Accounting for Outpatient Services Related to Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts;
1223	Other Comments Related to Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts;
1250	Accounting for Medical Services Purchased From Another Facility;
2220.3	Ancillary Service Expense;
2420.3	Description of Ancillary Service Expense;
7020.5	Instructions for Completing Trial Balance Worksheets and Supplemental Expense Information, Report Pages 17 and 18;
7020.12	Instructions for Completing Statement of Income - Unrestricted Fund, Report Page 8;
7030	Annual Reporting Forms (pages 8 and 17);
8200	Detailed Instructions for Completing the Quarterly Report; and
8300	Quarterly Reporting Form.

Eliminate Item H from Annual Disclosure Report Page 3.3

The managed care patient utilization data on report page 3.3 is being eliminated from that page because managed care patient utilization data is being added on the proposed new report page 4.1, Patient Utilization Statistics by Payor (see New Annual Disclosure Report page 4.1 below).

To implement this change, the following Manual sections are being changed

7020.15	Related Hospital Information; and
7030	Annual Reporting Forms (page 3.3).

Combine Annual Disclosure Report Pages 4.1 and 4.2 as Page 4

To reduce the reporting burden of expanded payer category detail, payer category detail by cost center is being eliminated from Hospital Annual Disclosure Report pages 4.1, Patient Census Statistics, and 4.2, Ambulatory, Ancillary, and Other Statistics. Average length of stay is also being eliminated from report page 4.1. The remainder of report pages 4.1 and 4.2 are being combined into new Annual Disclosure Report Page 4, Patient Utilization Statistics. These pages are being combined so the total patient utilization statistics for each cost center will be reported on the same report page.

To implement the above changes, the following Manual section is being added:

7020.16b	Instructions for Completing Patient Utilization Statistics, Report Page 4;

and the following Manual sections are being amended:

7020.16 Instructions for Completing Patient Census Statistics, Report Page 4.1; and
7030 Annual Reporting Forms (pages 4, 4.1, and 4.2).

New Annual Disclosure Report Page 4.1

Although payer category detail by cost center is being eliminated, new Annual Disclosure Report Page 4.1, Patient Utilization Statistics by Payor, is being added to show payer category detail for patient days and hospital discharges by type of care, and for outpatient visits by type of outpatient visit. Payer category detail is necessary to calculate revenue per day, revenue per discharge, and revenue per visit for each payer category.

Types of care are: acute care, psychiatric care, chemical dependency, rehabilitation care, long-term care, and other care. Separate lines showing patient days and hospital discharges by payer for nursery acute and purchased inpatient services are also included.

Types of outpatient visits are: emergency services (including psychiatric emergency room), clinics (including satellite clinics), observation care visits, psychiatric day-night care days, home health care services, hospice - outpatient, outpatient surgeries, private referred, and other. A separate line showing purchased outpatient service visits by payer is also included.

To implement the above changes, the following Manual section is being added:

7020.17b Instructions for Completing Patient Utilization Statistics by Payor, Report Page 4.1;

and the following Manual sections are being amended:

7020.17 Instructions for completing Ambulatory, Ancillary, and Other Utilization Statistics, Report Page 4.2; and
7030 Annual Reporting Forms (pages 4.1).

Changes to Annual Disclosure Report Page 8

The display of operating expenses is being changed from showing expenses by natural classification to showing expenses by type of service. This change is proposed to provide for the reporting of expenses related to purchased inpatient services and purchased outpatient services, and will be consistent with Generally Accepted Accounting Principles.

Since the detail for deductions from revenue has increased with the addition of managed care payer categories, the detail for deductions from revenue will be displayed as a separate section on report page 8 after net income. The detail for capitation premium revenue will also be displayed as a separate section following the deductions from revenue detail.

Annual Disclosure Report page 8.1, Statement of Income - Unrestricted Fund (Non-Operating Revenue and Expense), is being eliminated and the non-operating revenue and expense detail is being combined with report page 8, Statement of Income - Unrestricted Fund so all income statement items are on one report page. The new section on report page 8 displaying non-operating revenue and expense detail will follow the section displaying capitation premium revenue detail. The non-operating revenue and expense lines were renumbered to make room for the deductions from revenue and capitation premium revenue detail.

The above changes affect the following Manual sections:

7020.11 Instructions for Completing Statement of Income - Unrestricted Fund (Non-operating Revenue and Expense), Report Page 8.1;
7020.12 Instructions for Completing Statement of Income - Unrestricted Fund, Report Page 8; and
7030 Annual Reporting Forms (pages 8, and 8.1).

Change the Hospital Quarterly Reporting System to be a Windows 95 Application

All California hospitals must complete and electronically transmit the Quarterly Financial and Utilization Report using the Hospital Quarterly Reporting System (HQRS) software. The Office provides the HQRS software to California hospitals. Currently, the HQRS is a DOS-based personal computer (PC) application. However, because Windows 95 has become the standard operating system for IBM compatible PC's, DOS is no longer a viable operating system for most hospitals. Hospitals have also indicated difficulties in transmitting quarterly reports using the DOS based HQRS software. Because of these limitations with the DOS-based HQRS software, the Office is converting the HQRS software to be a Windows 95-based PC application for calendar quarters beginning January 1, 1999. Since hospitals must use the HQRS software to complete and transmit the Quarterly Financial and Utilization Report, each hospital must have the capability to use future versions of the Hospital Quarterly Reporting System (HQRS) software running under Windows 95 or later, or Windows NT operating systems for quarters beginning January 1, 1999.

The following Manual section is being amended to require Windows 95 or NT for using the HQRS software:

8001 Preface for Quarterly Reporting Requirements.

CCR Section 97018, Accounting and Reporting Manual for California Hospitals

Section 97018 of Title 22, California Code of Regulations, is being amended to reflect the effective date of the above changes to the Second Edition of the Manual.

CCR Section 97041, Report Procedure

Section 97041 of Title 22, California Code of Regulations is being amended to update references to: the Hospital Quarterly Reporting System to be version 1.4, the Instructions and Specifications for Developing Approved Software to Submit the California Hospital Annual Disclosure Report on Personal Computer Diskette to be the July 1997 issue, and the Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 ¼" or 3 ½" IBM PC Compatible Diskette to be the November 1997 issue. Copies of the Instructions and Specifications for Developing Approved Software to Submit the California Hospital Annual Disclosure Report on Personal Computer Diskette, July 1997 issue, and the Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 ¼" or 3 ½" IBM PC Compatible Diskette, November 1997 issue, are available for public review at 818 K Street, Sacramento, CA 95814. To request viewing these documents, call the Office at (916) 323-1955.

MINOR OR CLARIFYING MANUAL CHANGES:

In section 1200.1 of the Manual, the reference to "Patient Days" is being changed to "Patient (Census) Days" to clarify that patient days are census days and not discharge days. This change will make the reference to patient days consistent with other sections of the Manual.

In Manual section 2140, the account titles for Legacies and Bequests (account 1631), and Pledges (account 1632), are being changed to Legacies and Bequests Receivable, and Pledges Receivable, respectively, to indicate that these are receivable accounts.

Manual section 2210.3 is being amended to delete the incorrect listing of Therapeutic Radioisotope (account 4643) and Radioactive Implants (Account 4644), from Radiology - Therapeutic (account 4640). These subaccounts are already properly listed as subaccounts of Nuclear Medicine (account 4650).

Manual Section 2220.3 is being amended to change the titles of Durable Medical Supplies - Rented (account 7481) and Durable Medical Supplies - Sold (account 7482), to be Durable Medical Equipment - Rented, and Durable Medical Equipment - Sold, respectively. These are subaccounts of Durable Medical Equipment (account 7480).

Manual sections 2220.9 and 2420.9 are being amended to change the title of Leases and Rental - Equipment (account 8822) to Leases and Rentals - Fixed Equipment. This change is being made to clarify only expenses related to leases and rentals for fixed equipment are to be included in account 8822. Manual section 2420.9 is also being amended to change references in the Leases and Rentals (account 8820) description from "fixed assets" to "fixed equipment," and clarify that the cost of "major and minor movable" equipment leases and rentals must be charged to the using cost center.

In Manual section 2240.3, the title of employee benefit natural classification of expense .19, Other (Non-Payroll Related), is being changed to Other Employee Benefits (Non-Payroll Related) to clarify this classification of expense is for employee benefits.

In Manual section 2410.4, asterisks were placed next to Reinsurance Recoveries (account 5781) and Workers' Compensation Refunds (account 5782) to indicate these accounts are reportable accounts even though they are not zero-level accounts. This is consistent with the way these accounts are listed in Manual section 2210.4.

Manual sections 2420.2 and 4130 are being amended to rename the statistic for Observation Care (Account 7230) from "observation care visits" to "observation care days." This change is being made to use the proper terminology for labeling this statistic. The method of counting this statistic is not being changed.

In Manual section 2420.3, the description for Relative Value Units is being amended to delete the reference to "fiscal years beginning on or after 1990," and update the reference to "Relative Values for Physicians" to be the January 1998 edition. Relative Value Units are the standard units of measure for the following: Cardiology Services (account 7590), Radiology - Diagnostic (account 7630), Radiology - Therapeutic (account 7640), Nuclear Medicine (account 7650), and Ultrasonography (account 7670). A copy of "Relative Values for Physicians", January 1998 edition, is available for public review at 818 K Street, Sacramento, CA 95814. To view this reference, call the Office at (916) 323-1955. Copies may be ordered by mail from St. Anthony Publishing, Inc., 11410 Isaac Newton Square, Reston, VA 20190, or call 1-800-632-0123.

Manual section 2420.3 is being amended to clarify that an additional reportable statistic, number of renal dialysis outpatient visits, is required for Renal Dialysis (account 7740). This change is consistent with the reporting requirements in Manual section 7020.17. Renal dialysis outpatient visits are defined in Manual section 4130.

Manual section 2420.3 is also being amended to clarify that Purchased Inpatient Services (Account 7900) relate to inpatient services purchased from another hospital where the patients are <u>not</u> formally admitted as inpatients to the purchasing hospital. The patients are formally admitted as inpatients to the hospital providing the services.

Manual sections 2420.6, 2420.8, 2420.9, 4020 and 7020.5 are being amended to clarify the number of "full-time equivalent employees" is the number of "hospital full-time equivalent employees". The number of hospital full-time equivalent employees is the standard unit of measure for the following: Security (account 8420), Administration (account 8610), Management Engineering (account 8640), Employee Health Services (account 8660), and Employee Benefits (Non-Payroll Related) (account 8880).

Manual section 2420.9 is being amended to add Amortization - Intangible Assets (account 8891) as a subaccount of Other Unassigned Costs (account 8890) to be consistent with Manual section 2220.9.

Manual section 2420.10 is being amended to correct the subaccount numbers listed under Provision for Income Taxes (account 9900). These subaccount numbers are incorrectly listed as 9701, 9702, 9703, and 9704. They are being corrected to 9901, 9902, 9903, and 9904, respectively.

Manual section 2450 is being amended to add the a job title "Licensed Psychiatric Technician" to the Example Job Titles - Account Number Table as a natural account number .03 (the Licensed Vocational Nurse salaries and wages classification).

Manual section 7001 is being amended to correct section references to the Health and Safety Code and the California Code of Regulations.

Manual sections 7001 and 7020 are being amended to update the methods hospitals may use to submit their annual disclosure report. The current Manual does not mention that hospitals may transmit their annual disclosure report by modem to the Office's Bulletin Board System. After completing annual disclosure reports using Office-approved report preparation software, hospitals may now either 1) submit their annual disclosure reports on PC diskettes, or 2) transmit their annual disclosure reports by modem to the Office's Bulletin Board System (BBS).

Manual sections 7020.13 and 7020.16 are being amended to clarify that the "number of licensed beds" does not include licensed beds placed in suspense. This change is consistent with Manual section 8200.

Manual section 7020.24 is being amended to correct the format of the example Medi-Cal contract provider number.

Manual section 7030 is being amended to add a cover page to the section.

Report Page 3.1, Related Hospital Information, is being changed to delete the instruction for Item C that states "Complete column (8) for Management Fees, Property Leases and Rentals, and Data Processing only." Column (8) should be completed with all dollar amounts related to services, facilities, or supplies the hospital obtained from related organizations and with organizations with related personnel during the reporting period.

The Glossary (Appendix B) is being amended to include the definition of managed care.

STUDIES, REPORTS, OR DOCUMENTS RELIED UPON IN PROCESSING AMENDMENTS

In September of 1997, the Office mailed the Managed Care Payer Category Survey to the chief financial officers of all California hospitals and other affected parties. This survey was designed to see how many hospitals had managed care contracts, what kind of managed care data hospitals were already collecting, and how flexible hospitals' accounting and information systems were in making changes to separately record managed care data. The Office received 130 responses representing 147 hospitals and is relying on the Managed Care Survey Tabulation in making the proposed changes to the Manual.

A memorandum from the Department of Health Services' Disproportionate Share Unit, dated November 21, 1997, indicates that the proposed managed care payer categories will provide critical data needed for the Disproportionate Share Hospital (DSH) calculations. This memorandum also explains that the proposed Other Indigent payer category will allow hospitals that provide services to the medically indigent to report and receive DSH credit accordingly.

The Medicare and Medicaid Guide - Number 989 issued on January 15, 1998 explains that the Health Care Financing Administration's (HCFA) Center for Health Plans and Providers (CHPP) issued Operational Policy Letter Number 64, which requires managed care plans to work with hospitals to ensure that all hospital discharges of Medicare managed care enrollees are identified.

In February 1998, the Office received a letter from the Controller of Petaluma Valley Hospital indicating the difficulties of configuring the Hospital Quarterly Reporting System (HQRS) software to transmit the Hospital Quarterly Financial and Utilization Report. The letter also recommends that the Office make the HQRS software fully compatible with Windows 95 and be able to locate and set up the proper Com port, IRQ, initialization string and dialing prefix to allow for easier transmission of the quarterly report.

ALTERNATIVES CONSIDERED

The Office has determined in accordance with Government Code Section 11346.14 (b) that no alternative considered by the Office would be more effective in carrying out the purpose for which the actions are proposed or less burdensome to affected private persons than the proposed actions.